GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS, AND MARRIAGE AND FAMILY THERAPISTS
237 Coliseum Drive
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www.sos.state.ga.us/plb/counselors

MARRIAGE AND FAMILY THERAPY
SUPERVISION OF DIRECT CLINICAL EXPERIENCE VERIFICATION
FORM E

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- Please type or print clearly. For additional forms, please photocopy.
- Complete a separate form for each Supervisor listed on your Application.
- The number of hours and type of supervision required for licensure as an MFT depends upon the graduate degree that you hold. Seen Board Rule 135-5-.06.
- **Applicant** – Complete Part I.
- **Supervisor of Direct Clinical Experience** - Complete Part II.

PART I - TO BE COMPLETED BY APPLICANT

Name: Social Security #:

Address: _____
Street City State Zip

Employer:

Address: _____
Street City State Zip

Name of Supervisor:

The Supervision was in the practice of: ❒ MFT ❒ PC ❒ SW

DATES OF SUPERVISION:	FROM: Month/Year	TO: Month/Year
DURATION OF SUPERVISION:	TOTAL YEARS:	TOTAL MONTHS:

DESCRIBE THE PRACTICE:

DESCRIBE THE SUPERVISION:

ATTESTATION

I attest that the above information is a true and accurate representation of my practice and supervision.

_____ _____
Date Signature of Applicant

_____
Printed Name

FORM E - PART II - TO BE COMPLETED BY THE SUPERVISOR OF CLINICAL EXPERIENCE

INSTRUCTIONS:

- "Supervision" means the direct, i.e., face to face, clinical review, for the purpose of training, teaching, and promoting the development of clinical skill by a supervisor of a supervisee's interaction with client(s). Supervision may include, without being limited to, the review of case presentations, audio tapes, video tapes, and direct observations.
- Please review the Applicant's description of his/her practice and supervision. If you have any additional information that would assist the Board in making a decision on licensure for this Applicant, please provide that information below.

Name of Supervisor:

Address: _____
Street City State Zip

Type of License: ❒ MFT ❒ PC ❒ CSW ❒ PSYCHOLOGIST ❒ PSYCHIATRIST

License # State: Date Issued: Expiration Date: Years of Practice:

ADDITIONAL INFORMATION:

SUPERVISION
THIS APPLICANT RECEIVED THE FOLLOWING SUPERVISION FROM ME:

I supervised the above-named Applicant in the practice of:
❒ Marriage and Family Therapy ❒ Professional Counseling ❒ Social Work

DATES OF SUPERVISION:	FROM: _____ Month/Year	TO: _____ Month/Year
DURATION OF SUPERVISION:	TOTAL MONTHS:	TOTAL YEARS:
INDIVIDUAL: _____Hours/Week	GROUP: _____ Hours/Week	TOTAL HOURS:

I am a:

❒ GA Board-Approved MFT Supervisor _____ Date Approved

❒ AAMFT-Approved Supervisor _____ Term Expires On

❒ In Supervision of Supervision:
GA Board **or** AAMFT Approved Supervisor of Supervisor-in-Training:_____
Date Supervision of Supervision Began: _____

OATH

I attest that I served as this Applicant's supervisor as prescribed by law, and the description of the supervision provided in this Application is a true and accurate representation of my supervision with this Applicant.
I ❒ RECOMMEND ❒ DO NOT RECOMMEND this Applicant for licensure.

_____ _____
Date Signature of Supervisor

Subscribed to and sworn before me

this ____day of _____, _____

_____
Notary Public
My Commission Expires: _____ NOTARY SEAL